Thank you for the opportunity to comment on the GAPPA.

I am particularly interested in **Proposed Action 3.2: Implement the integration of patient assessment and provision of advice on physical activity by appropriately trained health and social care providers in primary and secondary healthcare and social services**

The importance of provided evidence-based recommendations is paramount if we are not to miss the opportunity to embed physical activity/exercise interventions in health care, particularly primary health care. When we do not base such interventions on a strong evidence-base, then this can have a number of negative repercussions. This is perhaps evidence by the recent example in UK primary care of the introduction of the General Practitioner Physical Activity Questionnaire as part of QOF assessments for patient diagnosed with hypertension. It was a failure, not least because the instrument was inadequate, but also it did not improve discussions between patient and doctor around exercise/physical activity. It has left a bad taste in the mouths of primary care workers yet the GPPAQ is still recommended for use in numerous NICE guidelines.

The other potential issue is the evidence base for brief advice and how we define it. The most cited review of Orrow et al 2012 suggests an NNT of 12 for one additional person to meet the recommend PA levels at 12 months. However, on closer inspection of the trials it appears ‘brief advice’ consisted of the following:

- **Most interventions included written materials and two or more sessions of advice or counselling on physical activity, delivered face to face.**
- **Advice or counselling was delivered by a combination of two professionals from different disciplines in most studies.**
- **Only one study reported an objective measure of physical activity in all participants. The mean intervention effect for this measure…was not significant at 12 month follow-up (~0.04 (95% confidence interval -0.16 to 0.08)).**

We also have recent systematic review evidence that face-to-face interventions for promoting physical activity in high income countries offer only small, heterogenous impact on physical activity uptake at 12 months and any noticed effect was underpinned by a tailored approach (Richards et al. 2013. Cochrane Database Syst Rev. 2013 Sep 30;(9):CD010392. doi: 10.1002/14651858.CD010392.pub2.) This impacts on the GAPPA Proposed Action 3.3 of having standardised protocols for assessment and brief advice.
Whilst introduction of the GPPAQ brought (or forced) physical activity discussions to the forefront in certain circumstances, it is still revealing that GPs (in the UK) lack confidence discussing physical activity with patients, with many not having heard of national guidelines [http://bjgp.org/content/early/2017/08/14/bjgp17X692513].

I also believe that the belief primary care professionals place in exercise as an effective intervention is affected by their perceived lack of success in changing patient behaviour (at least from brief interventions), with 0% rating there success at changing patient physical activity behaviour as ‘very successful’ and 32% rating success as ‘successful’. (Herbert et al. Br J Sports Med 2012;46:625-631).

This belief is further compounded, in my view, by the mixed messages health professionals receive from NICE. For example, this from the NICE PH44 Brief Advice for Adults in Primary Care:

> determination and support. Health care professionals can provide advice, encouragement and information, together with materials but ultimately may have limited scope to influence poor dietary habits and exercise which result in part from the busy and stressful pace of life and in part from...

Finally, belief in exercise as a ‘medicine’ may not have been widely adopted due to the evidence-base upon which it is based – or rather the scrutiny and attention paid to this evidence-base [http://www.bmj.com/content/353/bmj.i2468]. Trainee doctors, and increasingly current practicing clinicians, are more skilled in evidence-based methods through their education and professional development. This means that public health recommendations on physical activity based on observational studies in healthy cohorts may not transfer well to clinical settings, not least as the evidence underpinning much of the medicine they are taught about (pharmacological therapies) is based on high–quality randomised controlled trials (and systematic reviews thereof). To this effect, we have started to look at the evidence for exercise in preventing and treating non-communicable diseases with a view to providing health professionals with a thorough assessment of where there is evidence exercise really is medicine and where there still remains uncertainty [https://systematicreviewsjournal.biomedcentral.com/articles/10.1186/2046-4053-2-56].

More is also being done in terms of educating medical students on the benefits of physical activity [http://www.bases.org.uk/write/Documents/P24-25_Exercise_Medicine_(PAGES).pdf].

In identifying primary care as the key gatekeeper within the health care system for tackling the physical inactivity epidemic, the WHO mirrors other organisations for the same reasons – potential contact with the populous. However, careful consideration needs to be given to the ever increasing workload in
primary care and the opportunity cost of introducing more potentially cost-ineffective interventions (e.g. PA assessment). The action for brief advice may simply be repeating what we have already been recommending (with little success) up until now, at least in high income countries.

I look forward to discussions around the issues raised here and more importantly any emerging potential solutions.

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